BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **Syed Z. Tahir, M.D.** Holder of License No. 19801 For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-08-0250A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on February 5, 2009. Syed Z. Tahir, M.D., ("Respondent") appeared with legal counsel Stephen C. Yost before the Board for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue these Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 19801 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-08-0250A after receiving a complaint from a hospital employee regarding Respondent.

A. Patient LH

4. LH, a 26 year-old male, presented to the hospital on October 26, 2006, complaining of abdominal pain and was diagnosed with acute appendicitis by CT scan.

5. LH reviewed the CT scan report and agreed with the diagnosis of appendicitis.

6. During the Formal Interview Respondent read the following statement from the CT scan report: "There is a dilated 1.1 centimeter fluid-filled appendix seen within the right lower quadrant which contains six milliliters approximately of liquid." Respondent admitted he had never seen an appendix as small as 1.1 centimeters in an adult, but stated that the unusual size did not raise his suspicion regarding the nature of the structure identified on the CT scan.

7. After making the diagnosis of appendicitis, Respondent took LH to the operating room, where he performed a laparoscopic procedure to remove the structure identified in the CT scan report.

8. Respondent admitted that, after removing what he thought was the appendix, he did not feel the structure and did not go to the back table in the operating room to see if the item he had removed had a lumen present to differentiate it from an appendix epiploicae. In addition, he did not consider a pathological consultation to determine if the structure he had removed was, in fact, the patient's appendix.

9. The following day, Respondent was informed by the pathologist that LH's specimen was not an appendix, but was adipose tissue.

10. LH was returned to the operating room for an open appendectomy and was found to have retro-cecal acute appendicitis.

11. LH had an uneventful postoperative course and was discharged on October 31, 2006.

12. The standard of care in removing an inflamed vermiform appendix requires a physician to adequately perform the surgical procedure.

13. Respondent deviated from the standard of care by failing to perform the correct surgical procedure on LH.

14. By not removing the inflamed appendix during the initial operation LH suffered actual harm in that his treatment for acute appendicitis was delayed and required a second operation.

B. Patient BB

15. BB, a 51 year-old female, was admitted for treatment of a symptomatic incisional hernia of the abdomen on February 13, 2008. She had a history of liver disease, hepatitis, anemia and transfusions.

16. A previous CT scan of BB's abdomen demonstrated a small focal Spigellian hernia in the right lower quadrant, an enlarged spleen with fluid around it suggestive of cirrhosis of the liver and no evidence of bowel obstruction.

17. According to her medical history, in May 2007, BH had a right hemicolectomy during which her surgeon had to convert from a laparoscopic attempt to remove the colon to an open procedure due to adhesions.

18. Upon reviewing the CT scans, Respondent concluded that the Spigellain hernia was an incisional (ventral) hernia from that May 2007 open operation.

19. After obtaining consent, Respondent scheduled an elective laparoscopic repair of the hernia despite the fact that another surgeon who had attempted laproscopic surgery on this patient seven months earlier been forced to convert to an open procedure due to adhesions.

20. BH's pre-operative lab results indicated that she was mildly anemic (hemoglobin=11.7), thrombocytopenic (Platelet count =66,000) and had mildly elevated liver function tests (total bilirubin=1.4, AST=60).

21. Patients with thrombocytopenia, cirrhosis of the liver, portal hypertension and adhesions are at high risk for bleeding complications, especially during an abdominal procedure.

22. In light of the increased risk of complications presented by this patient, another physician declined to perform the elective hernia operation on BB on February 5, 2008, just eight days prior to Respondent's operation on her. There is no evidence in the record that Respondent was aware of this other physician's decision not to operate on BB.

23. In preparation for the operation, Respondent requested that 6 units of platelets be made available. There is no record of further work-up of the thrombocytopenia, anemia, abnormal liver function tests, enlarged spleen or the fluid surrounding it prior to the operation. Significantly, Respondent did not ensure that there was blood available for the patient in the event of intraoperative bleeding.

24. Respondent encountered extensive adhesions during the procedure,

and when attempting to place mesh, he created a hole in the small bowel.

25. The procedure was then converted from laparoscopic to open. Dense adhesions were present and, in order to adequately expose the injured bowel, BB required an extensive lysis of adhesions.

26. When Respondent began to mobilize the adhesions, the patient began to bleed. Respondent ordered packed blood cells, but the patient had unique antibodies, so there was a delay of two hours before the blood was available.

27. After the blood became available, Respondent performed the adhesiolysis, removed the injured bowel, reconnected the small bowel to the large bowel and closed the abdomen; effectively repairing the hernia. A total of four units of blood were given during the operation.

28. BB was transferred to the intensive care unit (ICU) where she was in disseminated intravascular coagulation (DIC). She was taken to the operating room later that evening for exploration.

29. She was returned to the ICU where her condition deteriorated and she went into multi-organ system failure. Following discussions with BB's family and her treating physician, support was withdrawn and comfort care measures were instituted. BB expired on February 15, 2008.

30. The standard of care requires a surgeon to evaluate the risks before performing elective laparoscopic surgery on a patient with cirrhosis and known adhesions.

31. Respondent deviated from the standard of care by performing elective laparoscopic surgery on a patient with cirrhosis where the chances of the laparoscopic procedure being converted to a more complicated and riskier open procedure were very high.

32. The standard of care requires a physician to properly prepare the patient for the anticipated operation and any reasonably expected problems that may be encountered.

33. Respondent deviated from the standard of care by failing to adequately prepare BB for an extensive operation, most notably by failing to ensure that sufficient blood was available prior to the surgery.

34. Respondent's deviations from the standard of care increased the risk of bleeding complications, which in fact occurred, and resulted in the death of the patient.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. §§ 32-1401(27)(q) ("[a]ny conduct that is or might be harmful or dangerous to the health of the patient or the public.")

and 32-1401 (27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, IT IS HEREBY ORDERED:

1. Respondent is issued a Letter of Reprimand.

2. The Board retains jurisdiction and may initiate new action based upon any violation of this Order.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 2nd day of April, 2009.

THE ARIZONA MEDICAL BOARD

By _____
LISA S. WYNN
Executive Director

ORIGINAL of the foregoing filed this 2nd day of April, 2009 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Mail this 2nd day of April, 2009 to:

Syed Z. Tahir, M.D.
Address of Record

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JAB - #409974